Printed: 08/08/2014 FORM APPROVED OMB NO. 0938-0391

[` '		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	17E242			B. WING		C 08/08/2014	
NAME OF PROVIDER OR SUPPLIER COMMUNITY HOSPITAL ONAGA LTCU			206 GR	ESS, CITY, STATE AND AVE YS, KS 66536	,		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION	
F 000	INITIAL COMMENTS			F 000			
	The following citations represent the findings of complaint investigation #77210.						
F 279 SS=D	483.20(d), 483.20(k)(COMPREHENSIVE (F 279			
	A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.						
	The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.						
	The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).						
	This Requirement is not met as evidenced by: The facility identified a census of 33 residents with 3 residents sampled for accidents. Based on observation, interview, and record review the facility failed to develop a comprehensive individualized plan of care for one (#2) resident of the sample.						
	Findings included: - The clinical record i	revealed the facility adr	nitted				
I ABORATOR'	resident #2 on 5/5/14	•			TITLE	(X6) DATE	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL AND PLAN OF CORRECTION IDENTIFICATION NUMBER		LIA [` '		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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F 279	Review of the initial and physical dated with recurrent falls. Review of the Physi 6/2/14 recorded diag Alzheimer's disease deterioration charac memory failure), Pa neurologic disorder tremor, rolling of the shuffling gait, muscl total self-care deficit Review of the admis Assessment (MDS) resident with a BIMS Status) score of three cognitive impairment in attention and behavior and the living envirous supervision for bed walking in the room unsteady balance, but without staff assistatindependently without staff assistation and transwareness. He/she ambulation and transwareness. He/she ambulation and transwareness and stabilize with reported falls prior to on his/her arms and	psychiatry evaluation his 4/23/14, recorded the residence of the residence	sident ed d ssive , and 3.0 the ental re d care equired atted ead one eary he ed, sises ed	F 279			

NAME OF PROVIDER OR SUPPLIER COMMUNITY HOSPITAL ONAGA LTCU STREET ADDRESS, CITY, STATE, ZIP CODE 206 GRAND AVE ST MARYS, KS 66536	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIATE DEFICIENCY) C 08/08/2014 (X5) COMPLETION DATE						
COMMUNITY HOSPITAL ONAGA LTCU 206 GRAND AVE	ECTIVE ACTION SHOULD BE COMPLETION DATE						
	ECTIVE ACTION SHOULD BE COMPLETION DATE						
PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX (EACH CORRE							
F 279 with ambulation. Review of the plan of care dated 5/16/14, recorded the resident with a self-care deficit due to impaired cognition and poor safety awareness. The resident was able to find his/her room now with a sign with [his/her name] in big letters. The resident's spouse reported the resident would lie down on the floor when his/her shoulder or back hurt. Nursing note dated 5/20/14 at 8:45 A.M. documented a housekeeping staff reported blood on resident's floor and the resident left elbow was bloody. Nursing staff treated the skin tear and placed Steristrips (thin adhesive strips which can be used to close small wounds) on the resident's elbow. Nursing note dated 6/25/14 timed 5:50 P.M., recorded the facility readmitted the resident and documented the resident fell at the acute care hospital, and transferred and ambulated independently bearing full weight on his/her extremities. The admission skin assessment recorded a dark red 1.5 centimeter bruise and stitches to the left eyebrow, multiple healing skin tears, bruising, both legs with two 0.5 centimeter scabbed areas, a 0.25 centimeter scabbed area on the ankle and a yellowish-purple bruise to left hip. Nursing note dated 6/25/14 at 9:50 P.M., documented the resident, went to hold his/her hand while ambulating, when the resident's hand slipped and the resident fell back and hit the occipital area (back of head). Review of the significant change MDS dated							

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		17E242		B. WING		C 08/08/2014	
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			ST MAR	YS, KS 665	336		
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	assistance from staff personal hygiene. Th balance, was unable assistance, had funct extremity, required a experienced one non		f f ipper and or				
	risk for pressure ulce Review of the plan of identified the resident and injury. The plan of in skin directed: Reposition every two redness lasted over 3 High risk for breakdoweight loss. Observe skin during change in temperatur Weekly skin assessm. The plan of care lack tears. Nursing notes dated	rs and had skin tears. f care dated 7/11/14 t with the potential for factor for potential alter hours and more often and minutes. who due to restlessness care for redness, pain, re, or open areas. hents by nurse with bath ed interventions for skin 7/3/14 (untimed) record	alls tration if and				
	drugged his/her arm started bleeding, and 1.8-centimeter skin to Review of the resider interventions to prote repeated skin tears. Nursing note dated 7	nt's plan of care lacked ct the resident's skin fro	m a om				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					(X3) DATE SURVEY COMPLETED		
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F 279	the bathroom floor w 2.0-centimeter abras a 3.5-centimeter by 3 the right elbow, and 3.0-centimeter abras Staff approximated t Steristrips. Observation on 7/30 resident laid on a pre mattress with a cut of P and Q provided per Direct care staff Q as sitting position and ti sitting position as dir resident's short slees sleeve t-shirt. Observithout arm protector arms, and Steristrips Observations of the A.M., 12:15 P.M., 12 P.M., 3:50 P.M., and resident in a short sl protectors to prevent On 7/30/14 at 1:30 F reported the resident decline since the ret hospital. Staff placed chair, and a new bed fall precautions. Direct resident took the arm them on. On 7/30/14 at 1:35 F reported the resident and was now a 2-pe	with a 2.5 centimeter by sion to the left lateral for 2.0-centimeter skin tear a 3.5-centimeter by sion to the right shoulder he skin tear to the elbow 1/14 at 9:15 A.M. revealed essure reducing winged but center as direct care ersonal care for the resident to a then held the resident to a then held the resident in rect care staff P replaced we shirt with a clean showation revealed the residers, multiple bruises to be a to the left wrist. Tesident on 7/30/14 at 12:36 P.M., 1:00 P.M., 2:414:30 P.M., revealed the eeve shirt without arms	to v with ed the edge staff lent. the d the rt dent both 1:00 0 e leeve c ute 's ce for the aff put	F 279			

	R/SUPPLIER/CLIA ATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 279 Continued From page 5 On 7/30/14 at 4:45 P.M. direct careported the resident had experie skin tears. The resident was in be assisted to change the resident's two hours. The resident should hiprotectors on, he/she did take the staff would try to put a long-sleev him/her. On 7/30/14 at 4:45 P.M. licensed reported the resident wore shorts Licensed nursing staff J stated he the resident in arm protectors from the resident from skin tear resident took them off, however sattempt long-sleeve clothing. Administrative nursing staff D conresident's plan of care lacked the arm sleeve protectors. The facility failed to develop a conplan of care regarding skin care fimpaired dependent resident. F 280 SS=D The resident has the right, unless incompetent or otherwise found to incapacitated under the laws of the participate in planning care and treatment. A comprehensive care plan must within 7 days after the completior	enced falls and ed now with staff positions every ave arm em off, and then e shirt on nursing staff J sleeve shirts. e/she had seen m day to day. rative nursing leeves to rs and the staff should ininistrative ed new care date as soon as ed. At this time intervention for emprehensive or this cognitive T TO E-REVISE CP adjudged to be the State, to reatment or the staff should to be the staff should intervention for eatment or the staff should the intervention for the staff should be the state, to reatment or the staff should be developed	F 279			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI. AND PLAN OF CORRECTION IDENTIFICATION NUMBER			` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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F 280	comprehensive asse interdisciplinary team physician, a registere for the resident, and disciplines as determ and, to the extent prathe resident, the resident, the resident legal representative;	ge 6 essment; prepared by ar n, that includes the atter ed nurse with responsib other appropriate staff i nined by the resident's n acticable, the participati dent's family or the resi and periodically review m of qualified persons a	nding ility in needs, on of dent's	F 280			
	This Requirement is not met as evidenced by The facility identified a census of 33 residents The sample included 3 residents reviewed for accidents. Based on observation, interview, a record review the facility failed to review and revise the plan of care for 1 resident (#1) relat to supervision, assistive devices, and prevent of falls.		ts. or and d ated				
	Sheet dated 7/1/14 r Parkinson's disease neurologic disorder of tremor, rolling of the shuffling gait, muscle Review of the Care A falls dated 10/11/13 r Parkinson's disease, (causes pain and stiff over time, the should move), and club foot which the affected fo	#1's Physician's Order ecorded the diagnosis (slowly progressive characterized by resting fingers, masklike faces, e rigidity, and weakness area Assessment (CAAs recorded the resident was frozen left shoulder ffness in the shoulder are becomes very hard to (a congenital abnormal to tappears to have bee the ankle). The resident	s) for ith aco				

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION	(1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 280 Continued From page of balance problems, expendence before admission received several rib fract wheelchair or rolling was resident with a BIMS (B Status) score of 15, white was cognitively intact. The documented the resident assistance with transfer hygiene, and toilet use, assistance of one staff of the room, in the corridor, are resident had limited fun (ROM) to one side of the and was unable to stable assistance. Review of the resident had and injuries. The resident had injuries. The resident device for ambulation, existed the interventions: Staff assistance with all Observe for safety when wheelchair or 4-wheeled Physical therapy and O admission and every 6 decline. Restorative nursing proto prevent decline in ROB Bed in low position at all except when providing of Keep room and hallway Remind the resident to	erienced many falls at a from which he/she ctures, and required a alker for mobility. Minimum Data Set 3 sed 4/2/14 recorded the Brief Interview for Menich indicated the residence of the same MDS and supervision with for walking in his/her and on the unit. The actional range of motione body, unsteady bal ilize without staff as comprehensive plane oblity dated 4/3/14 and the potential for factor required an assistic experienced balance on shoulder, and clubford transfers. In the resident used the dwalker. In cocupational therapy of months or with any new paramafter skilled the DM. Il times with brake locare.	on ance, on of lls ve oot, ne on oted rapy	F 280				

			A. BUILDING		(X3) DATE SURVEY COMPLETED	
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ITY HOSPITAL ONA	GA LTCU			36		
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Review of the resider fall sheets that docu 2/26/14, 3/16/14, 7/3 Nursing note dated the resident fell on the recliner from the a gait belt, due to rethe left side of his/he wear shoes and soo Staff educated the rusing a gait belt and ambulating. The facility investigating intervention for the rusing note dated recorded the resider at 4:00 P.M., using the staff assistance, who toilet seat, became the elbow and left chin juresident received a seas sistance with a gate ambulation. On 7/30/14 at 7:30 A back wheelchair at the dark shaded sunglate and ate breakfast in	ent's clinical record revealmented the resident fell 7/14, and 7/12/14. 7/7/14 at 6:25 P.M. recombe floor when ambulating bathroom. Staff failed to esident's request and pailer body. The resident did ests due to patient prefere esident about importance above or socks when attended to the esident to wear a gait be did ambulation. 7/12/14 timed 6:45 P.M. and the walker, gait belt, and the walker, gait belt for transfers and the dining room table, we see, special support shidependently.	on rded g to o use n on d not ence. e of w elt toilet one on the er left bow. staff a high ore oes,	F 280			
back wheelchair with	h special support shoes,	dark				
	OVIDER OR SUPPLIER ITY HOSPITAL ONA SUMMARY (EACH DEFICIENCY ML OR LSC I Continued From parassessment or char Review of the reside fall sheets that docu 2/26/14, 3/16/14, 7/ Nursing note dated the resident fell on the the recliner from the agait belt, due to rethe left side of his/howear shoes and soo Staff educated the rusing a gait belt and ambulating. The facility investigatintervention for the rowith all transfers and Nursing note dated recorded the resident 4:00 P.M., using staff assistance, who to to the rowith all transfers and soon of the rowith all transfers and Nursing note dated recorded the resident received a Nursing note dated documented the resident received a Nursing note dated recorded the resident r	OVIDER OR SUPPLIER ITY HOSPITAL ONAGA LTCU SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL RE OR LSC IDENTIFYING INFORMATION) Continued From page 8 assessment or change of condition. Review of the resident's clinical record reveal fall sheets that documented the resident fell 2/26/14, 3/16/14, 7/7/14, and 7/12/14. Nursing note dated 7/7/14 at 6:25 P.M. recothe resident fell on the floor when ambulating the recliner from the bathroom. Staff failed to a gait belt, due to resident's request and pain the left side of his/her body. The resident did wear shoes and socks due to patient prefere Staff educated the resident about importance using a gait belt and shoes or socks when ambulating. The facility investigation documented the neintervention for the resident to wear a gait be with all transfers and ambulation. Nursing note dated 7/12/14 timed 6:45 P.M. recorded the resident was ambulating to the at 4:00 P.M., using the walker, gait belt, and staff assistance, when he/she pivoted to sit to tollet seat, became dizzy, and bumped his/helbow and left chin jawline on the toilet. The resident received a small abrasion on the ell Nursing note dated 7/12/14 timed 7:10 P.M. documented the resident now required two sassistance with a gait belt for transfers and ambulation. On 7/30/14 at 7:30 A.M. the resident sat in a back wheelchair at the dining room table, we dark shaded sunglasses, special support shand ate breakfast independently. On 7/30/14 at 8:05 A.M. the resident sat in a back wheelchair at the dining room table, we dark shaded sunglasses, special support shand ate breakfast independently.	TOURIER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 8 assessment or change of condition. Review of the resident's clinical record revealed fall sheets that documented the resident fell on 2/26/14, 3/16/14, 7/7/14, and 7/12/14. Nursing note dated 7/7/14 at 6:25 P.M. recorded the resident fell on the floor when ambulating to the recliner from the bathroom. Staff failed to use a gait belt, due to resident's request and pain on the left side of his/her body. The resident did not wear shoes and socks due to patient preference. Staff educated the resident about importance of using a gait belt and shoes or socks when ambulating. The facility investigation documented the new intervention for the resident to wear a gait belt with all transfers and ambulation. Nursing note dated 7/12/14 timed 6:45 P.M. recorded the resident was ambulating to the toilet at 4:00 P.M., using the walker, gait belt, and one staff assistance, when he/she pivoted to sit on the toilet seat, became dizzy, and bumped his/her left elbow and left chin jawline on the toilet. The resident received a small abrasion on the elbow. Nursing note dated 7/12/14 timed 7:10 P.M. documented the resident now required two staff assistance with a gait belt for transfers and ambulation. On 7/30/14 at 7:30 A.M. the resident sat in a high back wheelchair at the dining room table, wore dark shaded sunglasses, special support shoes,	OVIDER OR SUPPLIER ITY HOSPITAL ONAGA LTCU SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 8 assessment or change of condition. Review of the resident's clinical record revealed fall sheets that documented the resident fell on 2/26/14, 3/16/14, 7/7/14, and 7/12/14. Nursing note dated 7/7/14 at 6:25 P.M. recorded the resident fell on the floor when ambulating to the recliner from the bathroom. Staff failed to use a gait belt, due to resident's request and pain on the left side of his/her body. The resident did not wear shoes and socks due to patient preference. Staff educated the resident about importance of using a gait belt and shoes or socks when ambulating. 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STATE, ZIP CODE 17E4ARYS, KS 66536 SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PROSEDED BY PLLIK REGULATORY) OR LSC IDENTIFYING INFORMATION) COntinued From page 8 assessment or change of condition. Review of the resident's clinical record revealed fall sheets that documented the resident fell on 2/26/14, 3/16/14, 7/17/14 at 6:25 P.M. recorded the resident fell on the floor when ambulating to the recliner from the bathroom. Staff failed to use a gait belt do to resident's request and pain on the left side of his/her body. The resident did not wear shoes and socks due to patient preference. Staff educated the resident boot importance of using a gait belt and shoes or socks when ambulating. The facility investigation documented the new intervention for the resident to wear a gait belt with all transfers and ambulation. Nursing note dated 7/12/14 timed 6:45 P.M. recorded the resident about importance of using a gait belt and shoes or socks when ambulating. 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NAME OF PROVIDER OR SUPPLIER COMMUNITY HOSPITAL ONAGA LTCU COMMUNITY HOSPITAL ONAGA LTCU STREET ADDRESS, CITY, STATE, ZIP CODE 206 GRAND AVE ST MARYS, KS 66536			(X1) PROVIDER/SUPPLIER/C		1 ' '	LE CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER COMMUNITY HOSPITAL ONAGA LTCU (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 280 Continued From page 9 sunglasses, and had a yellow-green bruise to the lower left jawline. Direct care staff Q and R placed a gait belt high under the resident's arms and transferred him/her from the high back wheelchair onto the toilet as the resident reached back to hold onto the toilet grab rails. On 7/30/14 at 11:06 A.M. direct care staff P and licensed nursing staff H placed a gait belt on the resident with a walker to stand and walk slowly to the bathroom.	ANDIEANO			-14.				С	
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sunglasses, and had a yellow-green bruise to the lower left jawline. Direct care staff Q and R placed a gait belt high under the resident's arms and transferred him/her from the high back wheelchair onto the toilet as the resident reached back to hold onto the toilet grab rails. On 7/30/14 at 11:06 A.M. direct care staff P and licensed nursing staff H placed a gait belt on the resident and assisted the resident with a walker to stand and walk slowly to the bathroom.	PREFIX	(EACH DEFICIENCY MUS	ST BE PRECEDED BY FULL RE		PREFIX	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI	ON SHOULD BE HE APPROPRIATE	COMPLETION	
lower left jawline. Direct care staff Q and R placed a gait belt high under the resident's arms and transferred him/her from the high back wheelchair onto the toilet as the resident reached back to hold onto the toilet grab rails. On 7/30/14 at 11:06 A.M. direct care staff P and licensed nursing staff H placed a gait belt on the resident and assisted the resident with a walker to stand and walk slowly to the bathroom.	F 280	Continued From pag	je 9		F 280				
On 7/30/14 at 11:15 A.M. direct care staff P reported the resident used his/her call light, did not get up on his/her own, and needed assistance of two staff for transfers. On 7/30/14 at 1:25 P.M. licensed nursing staff H reported the resident called for staff assistance, wore a special brace shoe for his/her club foot, and was transferred with a gait belt. The resident fell the day he/she returned from the hospital and required assistance of one staff before going to the hospital. On 7/30/14 at 1:35 P.M. direct care staff O reported the resident required assistance of two staff assistance for transfers from a chair. On 7/30/14 at 4:45 P.M. direct care staff S reported the resident used the call light and asked for two staff assistance with transfers. Direct care staff S revealed staff used a gait belt and the resident steadied his/her balance with a walker. On 7/30/14 at 4:50 P.M. licensed nursing staff J reported the resident required staff assistance with balance.	F 280	sunglasses, and had lower left jawline. Dire placed a gait belt high and transferred him/h wheelchair onto the to back to hold onto the On 7/30/14 at 11:06 A licensed nursing staff resident and assisted to stand and walk slow On 7/30/14 at 11:15 A reported the resident not get up on his/her of two staff for transferon on 7/30/14 at 1:25 P reported the resident wore a special brace and was transferred where the day he/she refrequired assistance of the hospital. On 7/30/14 at 1:35 P reported the resident staff assistance for transferor transferor on 7/30/14 at 1:35 P reported the resident staff assistance for transferor	a yellow-green bruise to ect care staff Q and R h under the resident's an er from the high back oilet as the resident reast toilet grab rails. A.M. direct care staff P of H placed a gait belt on the resident with a walk by to the bathroom. A.M. direct care staff P of the resident with a walk by to the bathroom. A.M. direct care staff P of used his/her call light, of own, and needed assisters. M. licensed nursing states a called for staff assistants shoe for his/her club for with a gait belt. The resident from the hospitate of one staff before going the direct care staff O of required assistance of ansfers from a chair. M. direct care staff S assistance with transfers wealed staff used a gait dided his/her balance with the call light and sesistance with transfers wealed staff used a gait dided his/her balance with the call light and sesistance with transfers wealed staff used a gait with the call light and the call light and sesistance with transfers wealed staff used a gait with the call light and th	and and the lker did stance aff H ace, ot, ident I and y to two	F 280				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/GIDENTIFICATION NUMBI		A. BUILDING		(X3) DATE SURVEY COMPLETED	
		17E242		B. WING		08	C 3/ 08/2014
NAME OF PR	OVIDER OR SUPPLIER	-	STREET ADDR	RESS, CITY, STATE	E, ZIP CODE	I	
COMMUN	ITY HOSPITAL ON	AGA LTCU		AND AVE RYS, KS 6653	6		
(X4) ID PREFIX TAG				ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 280	On 7/30/14 at 4:55 staff D reported staff D reported stadated the intervent after an incident. On 7/30/14 review lacked evidence reshoe/brace for the to use a gait belt wintervention for two transfers and amb. The facility failed the resident with a his	of P.M. administrative nurs aff added interventions and tions on the resident's car of the resident's plan of degarding the resident's speright clubfoot, the intervential transfers, or the costaff assistance with all ulation.	e plan care ecial ntion	F 280			
SS=D	The facility must e environment rema as is possible; and	RVISION/DEVICES nsure that the resident ins as free of accident had be each resident receives ion and assistance device		1 020			
	The facility identification The sample included accidents. Based of record review the interventions as placed for 2 (#2, #3) residents. Findings included:	is not met as evidenced led a census of 33 residented 3 residents reviewed from observation, interview, facility failed to provide anned for the prevention elents of the sample.	ts. or and of falls				
	resident #2 on 5/5. Review of the initial	/14. al psychiatry evaluation hi	story				

Printed: 08/08/2014 FORM APPROVED OMB NO. 0938-0391

(X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING _ COMPLETED 17E242 B. WING 08/08/2014 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **COMMUNITY HOSPITAL ONAGA LTCU 206 GRAND AVE ST MARYS, KS 66536** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PRÉFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE DATE OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 323 F 323 Continued From page 11 and physical dated 4/23/14, recorded the resident with recurrent falls. Review of the Physician's Order Sheet signed 6/2/14 recorded diagnoses that included Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), Parkinson's (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness), and total self-care deficit. Review of the admission Minimum Data Set 3.0 Assessment (MDS) dated 5/14/14 recorded the resident with a BIMS (Brief Interview for Mental Status) score of three, which indicated severe cognitive impairment. The resident displayed inattention and behaviors daily that affected care and the living environment. The resident required supervision for bed mobility, transfers, and walking in the room and corridor, displayed unsteady balance, but was able to stabilize without staff assistance. The resident ambulated independently without any mobility aid and had functional impairment of range of motion to one upper extremity. Review of the Care Area Assessment (CAA) for falls dated 5/16/14 documented the resident was at risk for falls related to his/her Parkinson's, dementia, and poor safety awareness. He/she was not steady with ambulation and transfers from the chair or bed, was able to stabilize without staff assistance, had no reported falls prior to admission, but had bruises on his/her arms and hands on admission. The resident had a shuffling gait and took small steps with ambulation.

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		17E242 B. WING		C 08/08/2014			
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE	•	
COMMUN	ITY HOSPITAL ONAG	A LTCU	206 GR	AND AVE			
			ST MAF	RYS, KS 665	536		
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F 323	Continued From page	e 12		F 323			
	Review of the fall risk	assessment dated 5/6	/14				
		core of (13) which indic					
		greater placed the resid	dent				
	at high risk for falls.						
	Review of the fall care	e plan dated 5/16/14 lis	ited				
	the interventions:						
		et at all times, place on					
	•	nction. The resident did	d not				
	tolerate the bracelet of Observe for increased						
		rse on some days relate	ed to				
	Parkinson's.						
		s when there were mor	e				
	people coming in and						
	Make sure resident's	snoes were tied.					
	Review of the fall risk	assessment dated 7/1	/14				
	documented a total so	core of (19) and indicat	ed a				
	_	eater placed the reside	nt at				
	high risk for falls.						
	Review of the signification	ant change MDS dated	I				
		ne resident with short a	nd				
	long term memory los						
	decision-making skills	for transfers, and total					
		for dressing, toileting a	nd				
		e resident had unstead					
		to stabilize without staf					
		ional limitation of one u					
		wheelchair for mobility,					
	assessment.	-injury fall since the prid	וע				
	23300011101110						
	Review of the Care A	rea Assessment (CAAs	s) for				
	falls dated 7/8/14, dod	_					
	readmitted the resider		.				
		nit. The resident was no on and transferring from					
	Stoday with ambulation	n and transferring non	'				

Printed: 08/08/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER AND PLAN OF CORRECTION IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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NAME OF PROVIDER OR SUPPLIER COMMUNITY HOSPITAL ONAGA LTCU			206 GR	RESS, CITY, STATAND AVE			
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F 323	chair and bed, and no staff assistance. The gait, took small steps not use a cane or ware the fall care plan data interventions: Chair and bed alarms. The resident would the before he/she got to Provided 1 to 1 care restless. Two staff to walk with balance problems and tolerate placement of Staff to hold the reside with him/her. Shuffling gait was we Parkinson's disease. Make sure the resident began hand hospice was promat beside bed. Nursing note dated 7 recorded staff found the bathroom floor with centimeter abrasion to 3.5 centimeter by 2.0 right elbow, and a 3.5 centimeter abrasion to approximated the ski Steristrips. Nursing nalarm did not sound. The facility provided of 7/10/14 documented connected. The facility fall with non-functionical fall with non-functionical care in the staff facility provided of 7/10/14 documented connected. The facility fall with non-functionical care in the staff facility provided of 7/10/14 documented connected. The facility fall with non-functionical care in the staff facility provided of 7/10/14 documented connected. The facility fall with non-functionical care in the staff fall with non-fu	ot able to stabilize without resident had a shuffling when ambulating, and lker. The detail times at all times. The chair when the resident was at the chair. When the resident would not gait belt. Hent's hands when walk with shoes were tied. Hospice services on 7/14 viding a hi-low bed with 1/10/14 at 8:15 A.M., the resident lying prone of the a 2.5 centimeter by 2 to the left lateral forearm of centimeter skin tear to	g did very it and it ing ed to 4/14 fall on 2.0 n, a the aff n ed on ted a sure	F 323			

(X2) MULTIPLE CONSTRUCTION

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER			A. BUILDING		(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER		STREET ADDRI		TE, ZIP CODE	•	
COMMUN	IITY HOSPITAL ONAC	SA LICU		ND AVE YS, KS 665	36		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	STATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL RE DENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 323	confirm the resident's setting and the alarm. Nursing note dated 7 documented staff for with the pressure ala assessment revealed the right frontal area a cold compress. The facility investigas staff found the resident his/her room with the by the resident. The face was against the 1.0 by 1.0 centimete frontal temporal area for the facility staff to spouse about chang. Observation on 7/30 resident laid on a premattress. Observation awithout extensive as revealed multiple browsteristrips to the left repositioned the resi Q reported the connection. At reported the tab was reported, he/she woon the unit. Observations of the A.M., 12:15 P.M., 12 P.M., 3:50 P.M., and	s bed was in the lowest in on. 7/26/14 at 8:00 P.M. 2/26/14 at 9:15 A.M. revealed at a second at a	floor ing ta to splied ented side he d a eft ded t's er. ed the edge t was l vation aff P staff box ll out aff Q off P blace it hair	F 323			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CI AND PLAN OF CORRECTION IDENTIFICATION NUMBE			` ′	LE CONSTRUCTION	COMPLET		
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F 323	Continued From page On 7/30/14 at 1:35 F	ge 15 P.M. direct care staff O		F 323			
	and was now a 2-pe	t used to walk on his/he rson transfer. The reside nair/bed for fall precaution	ent				
	On 7/30/14 at 1:25 P.M. licensed staff H reported the resident tried to get up by him/herself and required one to one assistance from staff when up and moving. The resident had bed and chair						
	alarms for safety. On 7/30/14 at 4:45 P.M. direct care staff S reported the resident had experienced falls and skin tears. The staff assisted to change the resident's positions every two hours and the resident had bed alarms. On 7/30/14 at 5:00 P.M. administrative nursing staff D confirmed the glider chair was in the resident's room and not replaced with a recliner as planned. Administrative nursing staff D reported the facility tried fall mats by the bed but they were a trip hazard and interfered with the resident's ambulation. Administrative nursing staff D reported staff added new care plan interventions along with the date as soon as the interventions were implemented. Review of the fall policy dated 11/2005 documented the purpose, to provide guidelines for the nursing caregiver to follow in order to appropriately assess and provide care for the resident who had fallen as well as to establish protocols for appropriate actions with regard to documentation, and notification of family and physicians. Nursing staff identified, instituted, and followed a specific course of action as soon as possible after the fall occurred.						
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			e sh to d				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER 1			(X2) MULTIPLE CONSTRUCTION		, ,	(X3) DATE SURVEY		
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NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE	•		
COMMUN	ITY HOSPITAL ONAG	A LTCU		AND AVE				
			ST MAF	RYS, KS 665	536			
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F 323	Continued From page	e 16		F 323				
	The facility failed to provide functioning assistive devices and devices as planned for this cognitive impaired dependent resident with a history of falls. - Review of the Physician's Order Sheet for resident #3, dated 7/1/14, recorded the diagnoses: right and left hip arthroplasty (surgical reconstruction process for the hip joints to improve function), dementia (progressive mental disorder characterized by failing memory and confusion), and psychosis (any major mental disorder characterized by a gross impairment in reality testing).							
	Review of the annual Minimum Data Set (MDS) 3.0 Assessment dated 3/5/14 recorded the resident with a BIMS (Brief Interview for Mental Status) score of 99, which indicated the resident was unable to answer the questions. Staff documented the resident with short and long-term memory loss, moderately impaired decision-making skills, required extensive assistance of one staff for transfers, and limited assistance from staff for bed mobility, walking on the unit and in room. This MDS documented the resident with unsteady balance, only able to stabilize with staff, and used a walker for mobility. The resident had functional impairment of range of motion to both lower extremities, was frequently incontinent, and experienced 2 non-injury falls since the previous assessment.							
	dated 3/7/14 for cogn was unable to answe	MS score with a diagno						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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F 323	him/herself only and directions. The CAA for falls daresident experience admission and fract resident experience fractured his/her writesident was at high cognition and balan without staff. The realarms, a hi-lo bed without staff. The realarms, a hi-lo bed without staff and required to the comparison of the plant o	It able to follow one-step of able to follow one-step of the divergence of the diver	d the her walk r the d the her walk r the d the her ss, r bed tance noom, he he her her her her her her her her h	F 323			

Printed: 08/08/2014 FORM APPROVED OMB NO. 0938-0391

(X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING _ COMPLETED 17E242 B. WING 08/08/2014 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **COMMUNITY HOSPITAL ONAGA LTCU 206 GRAND AVE ST MARYS, KS 66536** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PRÉFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE DATE OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 323 F 323 Continued From page 18 Fall risk assessment on admission and with MDS assessments or change of condition. Nursing restorative program to maintain range of motion after skilled therapy was completed. Interventions dated 6/5/14 included, when the resident was trying to get up, take him/her to the bathroom, he/she may need to toilet, and offer fluids. Review of the fall flow sheet dated 2/24/14 timed 9:00 P.M. documented staff found the resident kneeling on the fall mat next to his/her bed. The facility failed to provide an investigation for this incident. Review of the fall flow sheet dated 3/7/14 timed 9:45 P.M. revealed staff found the resident kneeling on the fall mat beside the bed, with the bed in the lowest position, and the bed alarm sounded. The facility failed to provide an investigation for this incident. Review of the facility provided fall investigation dated 3/16/14 documented the resident with Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness). The resident was oriented to person, place, and time, used a walker in his/her room, transferred him/herself, and was encouraged to call for staff assistance. The resident had an unsteady gait and generally required assistance of one staff with use of gait belt. Had historically utilized call light appropriately. The investigation revealed the resident did not utilize the call light, although it was within reach. The interventions directed staff to meet the resident's needs in a timely manner

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIES			(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN OF CORRECTION IDENTIFICATION NUM		IDENTIFICATION NUMBE	:R:	A. BUILDING			COMPLETED	
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COMMUN	ITY HOSPITAL ONAG	A LTCU		AND AVE	•••			
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F 323	Continued From page	e 19		F 323				
	regardless of how the assistance was required and to encourage the resident to use the call light for assistance.							
	Review of the fall flow sheet dated 5/7/14 timed 6:00 A.M. documented staff found the resident seated on the floor beside the bed with the mat pushed away from the bedside. The facility failed to provide a fall investigation for this incident.							
	Review of the nursing note dated 6/8/14 timed 8:15 P.M., documented staff responded to a chair alarm and found the resident on the floor in the dining room. The fall was not witnessed by staff and the resident had a 2 centimeter hematoma (collection of blood trapped in the tissues of the skin or in an organ, resulting from trauma) bruise on the dorsal (back side) surface of the right hand.							
	Review of the fall investigation dated 6/8/14 documented the resident with a primary diagnosis of dementia, history of falls, and impulsive with cares and activities. The resident was left in the dining area without close supervision. Review of the facility provided investigation recorded the intervention, staff not to leave the resident unattended in the dining and living room.							
	Nursing note dated 7/28/14 (untimed) documented staff lowered the resident to the floor. The resident stated, "I let go of my walker and went down."							
	staff silenced the charassisted the resident gait belt, and walked	14 at 12:22 P.M. reveal ir pressure alarm and to stand with a walker a the resident from the livesident's bathroom. The	and ving					

17E242 B. WING C 08/08/2014	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIEI IDENTIFICATION NUM			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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COMMUNITY HOSPITAL ONAGA LTCU 206 GRAND AVE ST MARYS, KS 66536	COMMUN	ITY HOSPITAL ONAG	A LTCU			536		
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resident walked with a shuffling gait and every few steps staff readjusted and straightened the walker direction, while holding onto the walker and gait bett. On 7/30/14 at 1:25 P.M. licensed nursing staff H reported the resident had dementia, required staff observation when up in a chair, one to one assistance from staff, and a gait bett when he/she walked. On 7/30/14 at 1:35 P.M. direct care staff O reported the resident had dementia and required one to one assistance for overything. Staff tolleted the resident every 2 hours and before and after meals. On 7/30/14 at 1:30 P.M. direct care staff P reported the resident was a fall risk, had bed and chair alarms, a Hi-low bed, and a mat on the floor. Staff kept the resident her sident in line of sight" as he/she would get up and just go and staff toileted the resident every 2 hours. On 7/30/14 at 4:45 P.M. direct care staff S reported the resident had alarms, did not use the call light, needed staff with him/her when walking, and staff were not to leave him/her alone in their room. On 7/30/14 at 4:50 P.M. licensed nursing staff J revealed the resident was a fall risk, had alarms, a mat at the bedside, sat in the living room recliner most of the day, and staff kept the resident in view. When the resident tried to get up staff took the resident to the bathroom. On 7/30/14 at 4:55 P.M., administrative nursing staff D reported staff added interventions and dates to the care plan after an incident.	F 323	resident walked with a few steps staff readju walker direction, while and gait belt. On 7/30/14 at 1:25 P. reported the resident observation when up assistance from staff, walked. On 7/30/14 at 1:35 P. reported the resident one to one assistance toileted the resident eafter meals. On 7/30/14 at 1:30 P. reported the resident chair alarms, a Hi-low floor. Staff kept the rehe/she would get up a the resident every 2 h. On 7/30/14 at 4:45 P. reported the resident call light, needed staff and staff were not to broom. On 7/30/14 at 4:50 P. revealed the resident a mat at the bedside, recliner most of the diresident in view. Whe staff took the resident. On 7/30/14 at 4:55 P. staff D reported staff and reported reported staff and reported reported staff and reported reporte	a shuffling gait and ever sted and straightened to holding onto the walk. M. licensed nursing state had dementia, required in a chair, one to one and a gait belt when how the state of th	aff H d staff d staff e/she uired ff e and d and e as ideted e the alking, their aff J rms, get up	F 323			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C AND PLAN OF CORRECTION IDENTIFICATION NUMBER				LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
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F 323	Continued From pag	e 21		F 323				
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